Continuum of Care, Best Practices

2014

Introduction

Homelessness in the United States remains a complex issue – one associated with many challenges and variables that no single remedy may correct. From the time that people considered it a problem in the late 19th century to the growing awareness and understanding in the 21st century, many advocates for people experiencing homelessness, with the incorporation of public and private partnerships, are coming up with ways to reduce or possibly end this injustice. Affordable housing development is arguably the most practical solution. Nonetheless, for many homeless individuals, other supportive services and programs must be offered to effectively increase their stability.

Much like the rest of the country, central Alabama continues to have a problem with homelessness. According to the One Roof 2014 Point in Time Count, 1329 people in area experience homelessness on any given night. While the total number of homeless individuals identified during these counts has decreased since 2005, the number of homeless individuals within subpopulations of the broader homeless population has fluctuated over the years. These variations highlight where the greatest needs can be met. In the most recent year, the largest subpopulations include those with chronic substance abuse, severe mental illness, and multi-episodic or long lasting (chronic) homelessness. Each group requires its own degree of specialized care in order increase the likelihood of housing.

2005 – 2014 Homeless Subpopulation Count

Homeless Subpopulations	Total						
	2005	*2007*	*2009*	*2011*	*2012*	*2013*	*2014*
Chronically Homeless	648	516	611	536	484	427	313
Chronically Homeless Families						6	9
Severely Mentally Ill	922	810	896	830	717	395	423
Chronic Substance Abuse	1316	1105	1240	1003	894	435	412
Veterans	447	443	459	281	175	194	174
Persons with HIV/AIDS	168	155	166	156	132	63	72
Victims of Domestic Violence	161	130	161	144	101	143	209
Unaccompanied Youth (under 18)	2	34	54	49	25	10	4

The following sections of the report will discuss in detail different programs that have effectively addressed the needs of these homeless subpopulations throughout the country. By exploring models deemed "best practices" by other agencies, we hope to build a system based on prevention and care that will best serve our areas' homeless population. We specifically present programs for Continuum of Care Success, Housing Programs Success, and for Increasing Economic Security.

Best Practice for Continuum of Care Success

Measuring Vulnerability

Providers have begun to develop tools designed to assess instability and vulnerability that outreach and intake coordinators may utilize to better understand their clients' states of susceptibility to illness and continued homelessness. With the necessary training completed, such tools may be used by anyone working with a service agency, not only experienced professionals. Many cities around the country have begun to utilize tools that not only assess clients' states of homelessness but also their vulnerability to risk factors associated with health and wellbeing. Two instruments, Common Ground's Vulnerability Index (New York) and DESC's Vulnerability Assessment Tool (Seattle), stand out as best practices.

Originally developed by Dr. Jim O'Connell of Boston Healthcare for the Homeless, the Vulnerability Index (VI) is a survey and analysis methodology used for "identifying and prioritizing the street homeless population for housing according to the fragility of their health."[1] This index helps outreach workers, social workers, and healthcare providers to determine homeless clients' health statuses by identifying mortality risks. Higher mortality risk marker are listed below:

- 3+ hospitalizations or emergency room visits in a year
- 3+ emergency room visits in the previous three months
- Aged 60 or older
- Cirrhosis of the liver
- End-stage renal disease
- History of frostbite, immersion foot, or hypothermia
- HIV+/AIDS
- Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition

These markers identify clients who are most susceptible to dying on the streets, aiding providers in targeting services to those most vulnerable. In addition, the index can estimate the costs of healthcare services provided to those surveyed, highlighting the burden these costs impose upon cities due to clients' routine emergency room use.[2] The city of Santa Maria, California announced their most recent results of the VI, illustrating that nearly half of its respondents have no health insurance and regularly use emergency rooms or clinics to receive care. Consequently,

[1] Community Solutions
[2] Journey Home, Inc. (2010)

the taxpayers paid nearly $5 million in emergency and hospitalization costs this past year alone.[3] The VI serves a dual purpose: it calls attention to the needs of the most vulnerable homeless individuals while simultaneously highlighting the need for stable housing as the cornerstone of quality healthcare.

Currently, Fort Worth County, Texas; the Urban Ministry Center of Charlotte, North Carolina; the New Mexico Coalition to End Homelessness in Albuquerque, New Mexico; and administrators in Skid Row of Los Angeles, California use this index. With the help of the VI, agencies, cities, and counties, have stabilized vulnerable individuals and families. The county of Santa Barbara, for example, housed over 181 vulnerable individuals and family members since 2011, representing 92 households. They chose to implement the Vulnerability Index in order "to capture more details to determine who are the most vulnerable, to prevent deaths and target [their] strategies.[4]" Application of the VI in New Hartford, Connecticut resulted in the identification of 176 medically vulnerable individuals in 2010. Of these individuals identified, 46 were housed by May of that year.[5] Journey Home, Inc., the nonprofit organization who organized the VI administration and analysis, has continued to conduct the VI survey in order to better recognize the most vulnerably homeless individuals in need of housing and to "challenge the public's conception of the crisis that is Homelessness – to make it a public health issue, and to help address commonly misinformed stereotypes."[6] From May 9th -13th, 2011 during the hours of 4:45am and 11:00pm, volunteers canvassed the streets and shelters of targeted areas in Hartford, East Hartford, Manchester, and Vernon. The number of volunteers willing to help with the survey administration doubled from the previous year. In addition, results from this survey showed a drop in medically vulnerable individuals from 176 to 139.[7] Similar communities throughout the country have continued to utilize this tool, modifying it to meet the specific needs of their respective populations.

While the VI show the correlation between increased mortality risks and homelessness, studies indicate that modifications are necessary for the Index to be effective in areas outside the Northeast. For example, the city of Fort Worth recently adopted a tailored form of the VI to fit their city's needs. The Fort Worth Vulnerability Assessment excludes questions about cold weather injuries includes questions regarding sexual assault while homeless, heart surgery, being blind or deaf, and having an 8th grade education or less. Research found that after modifying the VI to broaden the definition of vulnerability beyond mortality, content validity increased making for a more effective tool.[8] Common Ground's version lays the groundwork for a practical, usable model that, through modification, can meet the needs of the One Roof Continuum of Care.

Alternately, DESC created the Vulnerability Assessment Tool (VAT) to measure "a homeless person's vulnerability to continued instability."[9] The VAT includes a mortality risk scale similar

[3] Asman, A (2013, March 27)
[4] Central Coast Collaborative on Homelessness (2013)
[5] Journey Home, Inc. (2010)
[6] Journey Home, Inc. (2011)
[7] Journey Home, Inc. (2011)
[8] Spence-Almaguer, E., Cronley, C., & Petrovich, J. (2013).
[9] DESC (2010)

to Common Ground's VI. Nonetheless, this model differs from the VI by measuring vulnerability on a more comprehensive scale:

- Survival Skills
- Basic Needs
- Indicated Mortality Risks
- Medical Risks
- Organization/Orientation
- Mental Health
- Substance Abuse
- Communication
- Social Behaviors
- Homelessness

These domains are not limited to mortality but are expanded to encompass factors that might perpetuate homelessness for a client. This model identifies broad markers for increased vulnerability, monitoring instability, which offers more insight into the needs of the homeless population than the VI. In addition, it helps to distinguish between previously evaluated individuals. According to the DESC tool, clients may vary along the vulnerability spectrum. Some individuals may suffer from vulnerabilities in areas where others do not or may suffer differently between domains, i.e. differences between communication issues, substance abuse issues.[10] By assessing symptoms relating to chronic conditions, the VAT assists providers in identifying individuals who may be eligible for SSI/SSDI benefits and individuals who are most in need of housing. Nonetheless, an assessment score only helps to identify vulnerability and risk for continued homelessness, not provide a comprehensive list of services, support, medical care, etc. needed by clients.[11] However, the VAT helps providers understand homelessness from a more holistic perspective, allowing them to better focus on clients who are at a greater risk of continued homelessness.

A number of factors should be considered when bringing a vulnerability measurement tool to Birmingham, including administration, cost, and effectiveness. Both Common Ground and DESC provide training to organizations interested in utilizing their tools. While numerous volunteers with minimal guidance may administer the VI, DESC recommends that the VAT be proctored by a limited number of staff trained by DESC technical assistance. In addition, the DESC allows for organizations trained to use the VAT to receive received follow-up "train the trainer" instruction[12] so they can handle their own training needs moving forward.

Both tools provide cost-effective results to benefitting agencies. With regard to the VAT, DESC does not charge for the use of its tool and only has a few stipulations for utilizing their instrument:[13]

---

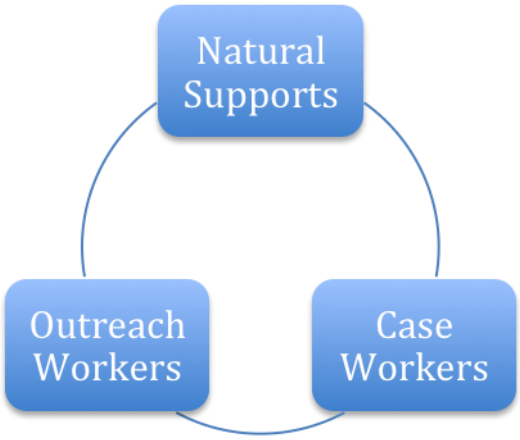
[10] Karyn Boerger (March 2013)
[11] DESC (2010)
[12] DESC (2010)
[13] DESC (2010)

- Receiving training by DESC in the proper implementation of the Vulnerability Assessment Tool;
- Following DESC's instructions for implementation of the tool, including limiting the pool of assessors to the minimum necessary;
- Crediting DESC in the organization's use of the tool; and
- Providing feedback and/or de-identified data to DESC to assist with tool improvements.

Each tool's effectiveness depends upon its aims. Both tools can be used to objectively understand homeless individuals' vulnerability and to prioritize services. The VI aims to identify homeless persons with greatest risk of death, while the VAT seeks to identify factors that perpetuate instability.

Navigation

Individuals who are attempting to gain housing often require a strong network of support to reach stability. Arizona Coalition to End Homelessness' Project H3: Home, Health, Hope has developed an innovative system that utilizes the three basic supports available for people experiencing homelessness and has merged them together to create a unique service delivery system carried out through specialists known as navigators.[14] Navigators, also known as peer support workers, help to guide clients through treatment programs and the housing process. As formerly homeless individuals, these peer support specialists can better connect with clients and build trust with clients along their journey toward increased stability.



This delivery system is built upon the following principles:[15]

- Services are patient-centered and dynamic
- Recovery-oriented care is utilized

[14] Project H3 (2012)
[15] Project H3 (2012)

- The scope of work is unlimited
- Navigator services supplement those already in place
- Support continues after stability is attained

These principles illustrate the powerful role that the navigator plays in the client's life. Navigators remain flexible to meet the needs of each individual; attempt to bring meaning and purpose back into the client's life by drawing on recovery-oriented care; begin their work by stabilizing clients and reintegrating them into the community; do "whatever it takes" to keep clients housed and to boost their quality of life; serve as a friend and advocate offering advice, transportation, and support to clients when they need it; help participants obtain the skills they need to gain stable housing; collaborate with existing social service networks; and continue support beyond housing and stabilization. In addition to the services provided to clients, navigation offers a wonderful opportunity for the peer support specialists themselves. As formerly homeless individuals, navigators have the ability to share their stories with clients, providing an avenue for self-advocacy in addition to an understanding of issues that clients face. Furthermore, the role of peer support specialist offers employment to formerly homeless individuals at a fairly low cost to agencies. Within Project H3's overall annual budget, the navigator costs equal $41,000 per peer support worker. This figure accounts for an annual salary of $30,000.[16]

Project H3 has shown some promising results in housing clients through the efforts of navigation. In the past year, 47 clients received housing and utilized Housing First, harm reduction, and peer support as a part of the H3 program. Results showed that after twelve months, 98 percent of participants remained in housing. Results also indicate lowered incarceration rates, decreased instances of substance abuse, and increased participant quality of life. Six months after move-in, statistically significant changes were seen in clients' reported substance use, quality of life and use of primary care physicians. In addition, "significant reductions in participants' report of going to jail and prison between move-in and 6 months were found."[17] While the most statistically significant results were shown at the six-month mark, similar trends continued up until a year.[18] Peer support, along with Housing First and harm reduction, encouraged participant retention in stable housing.

Bringing housing-specific navigation to Birmingham could prove quite effective. This practice provides employment for formerly homeless individuals and helps alleviate the stress of stabilization for currently homeless individuals. Navigation is a valuable tool that could be implemented with little cost to agencies other than employment of the specialists. The high rate of success shown by H3's program is promising.

Centralized Intake

[16] Monthly "All Hands on Deck" Call, 100,000 Homes Campaign (2013)
[17] Bean, K.F., Shafer, M.S., Glennon, M. (2013)
[18] Bean, K.F., Shafer, M.S., Glennon, M. (2013)

Centralized intake remains a key factor in optimizing homeless prevention efforts and other service programs. It allows service providers to efficiently provide vital resources to individuals and families. Non-coordinated systems are challenging for clients and providers because of scattered intake points and not easily accessible services.[19] Additional staff, time, and funding are required to provide intake and assessment, limiting the availability of case management and housing placement. Centralized intake allows agencies to focus more on treatment and housing services while offering intake and assessment at either a single location or in a coordinated manner throughout a community.[20] Both governmental and nongovernmental entities view centralized intake as a best practice among CoC agencies. The U.S. Department of Housing and Urban Development suggests that centralized intake systems should:[21]

- Advertise ways to access centralized intake;
- Provide a means to request assistance, such as a walk-in center or a 2-1-1 call center;
- Establish individuals' housing and service needs, program eligibility, and priority;
- Inform clients about programs and agencies that can meet their needs;
- Refer the person to appropriate programs or agencies, and in some cases, make program admissions decisions.

Centralized intake streamlines the information and referral process for homeless clients, providing order and structure during a challenging and stressful time in their lives. Often, centralized intake points provide basic services in-house to clients, including counseling, emergency funds, motel vouchers, bus tokens, food, and clothing. [22] In this way, clients receive immediate services before they work with agencies to become stably housed. Centralized intake acts as a practical first stop for clients seeking assistance.

CoCs offer centralized intake through four different models: mixed centralized, single location centralized intake, multiple location intake, and phone-only intake. Below are a few examples of agencies that use such methods.[23] [24]

Mixed Centralized Intake	• San Francisco – Connecting Point • 825,863 people in San Francisco (2012 U.S. Census estimate) • 5,895 homeless individuals (2012 PIT count) • Places families into specific shelters based on specific needs identified by screening and assessment processes • Two step intake process – 1) homeless family calls hotline for phone intake and 2) attends in-person appointment for in-depth interview; then family is provided with services

[19] National Alliance to End Homelessness, One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families (2011)
[20] Culhane, Dennis P. Stephen Metraux, Jung Min Park, Maryanne Schretzman, and Jesse Valente (2007)
[21] U.S. Department of Housing and Urban Development (2010)
[22] National Alliance to End Homelessness, One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families (2011)
[23] Polk County Housing Trust Fund (2012)
[24] *State and County QuickFacts*

Single Location Centralized Intake	• Hennepin County Minnesota CoC • 1,184,576 people in Hennepin County (2012 estimate) • 3,285 homeless individuals (2012 PIT count) • Only one access point for homeless individuals and families – Hennepin County Social Services Building – NO TELEPHONE HOTLINE • Shelter stays are viewed as last resort – staff attempts to place client into supportive housing as quickly as possible
Multiple Location Centralized Intake	• Alameda County California CoC • 1,554,720 people in Alameda County (2012 estimate) • 4,257 homeless individuals (2012 PIT count) • Eight Housing Resource Centers distributed throughout county to assess intake • Each center utilizes the same assessment tools, data collection, and targeting strategies • Alleviates difficulties of coordinating multiple location intake system by holding group meetings – lines of communication are kept open to stay on same page
Phone-Only Intake	• Interfaith Hospitality Network of Greater Cincinnati[25] • 296,550 people in Cincinnati (2012 estiamte) • 1,654 (2012 PIT count) • Individuals and families who are experiencing homelessness or are on the verge of experiencing homeless may call 381-SAFE (7233) to speak to an intake specialist. This intake specialist will make appropriate referrals into a partner agency's program. • Centralized Access Point (CAP) takes calls from 9:00 AM to 8:00 PM Monday through Friday and 10:00 AM to 2:00 PM Saturday and Sunday.

While Birmingham's population (212, 038 people) is small in comparison to the cities above, the most recent Point in Time indicates a total homeless population of 1,469, which represents 0.69% of the total population, nearly equal to San Francisco (0.71%) and higher than Hennepin County (0.28%) and Alameda County (0.27%). Thus, Birmingham can reasonably apply the successful practices from these communities. Multiple-location centralized intake models are typically most effective in large communities or communities with a poor transit system, and mixed centralized intake models incorporate a dedicated phone line that can also address the issues of transportation and "after hours" emergencies.[26] Due to Birmingham's poor transit system and the emergent nature of housing crises, a multiple-location, mixed centralized intake model is a comprehensive and efficient option.

Systems Evaluation

One of the best ways to understand a community's progress in housing individuals and families can be illustrated through quantifiable outcome measures. Such measures will help a community adhere to the HEARTH Act and to inform CoCs about the successful or unsuccessful nature of their programs, allowing funding alterations based on the results.[27] One Roof conducts the annual Point-in-Time Count, illuminating the decline in homelessness over the years.

[25] Greater Cincinnati Homeless Coalition, 2013
[26] Polk County Housing Trust Fund (2012)
[27] National Alliance to End Homelessness, *Becoming a Data Driven System: Columbus, Ohio*

Additionally, One Roof and its member agencies could greatly benefit from adopting a evaluation measures designed to gauge the mitigation of homelessness within our community.

Depending on the program being evaluated, different types of outcome measures should be considered. For example, markers for Housing First policies may include length of shelter stay, housing placement, housing stability, housing outcomes, recidivism rates, residence health, and increase in economic stability. The Community Shelter Board (CSB) in Columbus, Ohio uses several measures to evaluate systems and outcomes of homeless programs, including length of shelter stay and number of detoxification related program exits. Other programs measurements include "Successful Housing Outcomes" and "Employment Status at Exit"[28]. Both measurements help to gauge how successfully programs stabilize clients. CSB offers an array of tools to assess what is working to house and support homeless clients.

Below is a rating scale of how the CSB measures its agencies' programs. This scale is based upon a wide variety of outcomes measurements:[29]

- Average length of stay
- Cost per household
- Cost per successful housing outcome
- Employment status at exit
- Households served
- Housing retention
- Housing stability
- Interim housing stability
- Movement
- Negative reason for leaving
- Pass program certification
- Recidivism
- System occupancy rate
- Successful housing outcomes
- Turnover rate

Agencies are evaluated based upon the above system measurements and are given a "High," "Medium," or "Low" rating accordingly.

[28] Community Shelter Board, *FY2013 Program Performance Standards* (2013)
[29] Community Shelter Board (2013). The Columbus Model: Performance Measurement & Evaluation

Columbus Model: System/Program Evaluation Ratings[1]	
High	Achieve at least 75% of the measure outcomes and at least one of the successful housing outcomes (either number or percentage outcome)
Medium	Achieve at least 50% but less than 75% of the measured outcomes
Low	Achieve less than 50% of the measured outcomes

The Columbus model for measuring outcomes has effectively conveyed the reduction of family homelessness from over 1,200 families in 1997 to 746 in 2009. Only one percent of single adults returned to homelessness during that time.[30] The Community Shelter Board continues to provide the most funding to agencies that have the highest performance ratings. Programs with "low" success ratings on their evaluations are considered "programs of concern" and are monitored accordingly. If agency program continues to rate poorly, CSB works with the agency through a Quality Improvement Intervention Program (QII). The QII determines why the program is not performing well, identifying which barriers may hinder specific programs from achieving high performance ratings, i.e. the introduction of a new program, shifts in client demographics, extenuating circumstances beyond the agency's control, etc. [31]

In addition to the systems evaluations utilized by the Community Shelter Board, other agencies have created tools for quantitatively measuring program and clients outcomes. Michigan's Campaign to End Homelessness provides a good example of such ingenuity. Similar to the Community Shelter Board, Michigan's Campaign evaluates outcomes related to eliminating homelessness. These include positive exits to housing, financial stability; employment at exit, etc.[32] From 2007 to 2012, there has been an increase of almost 15,000 positive exists from emergency shelter care to permanent supportive housing. Additionally, within this same time period, there was an increase in 6,029 successfully employed clients.[33]

It could be beneficial for One Roof to revitalize its evaluation of different programs and services that are utilized by clients. While great strides have been made to decrease the number of homeless individuals and families within central Alabama, a more data-driven system with increased measurements of different outcomes could prove to help reduce these figures even more. Programs with the highest performing outcome ratings would be given priority funding, helping to further decrease the amount of homeless individuals each year. In addition, programs with low performance ratings could benefit from actions taken to understand where their weaknesses lie and to take measures needed to improve outcomes.

Harm Reduction

[30] Polk County Housing Trust Fund (2012)
[31] Community Shelter Board (2013). The Columbus Model: Performance Measurement & Evaluation
[32] Thecampaigntoendhomelessness.org, 2014
[33] Thecampaigntoendhomelessness.org, 2014

As the 2013 One Roof Point-in-Time Count illuminates, chronic substance users ranked as the largest subpopulation of homeless individuals in the Birmingham area. With regard to service eligibility for individuals with chronic substance use, most shelters and transitional housing programs uphold abstinence-only policies upon client entry. Such policies and programming strategies are widely used throughout the U.S. – in fact, "these types of services comprise nearly 99% of all substance abuse facilities in the United States." Evidence supports that abstinence-based treatment and policies are in fact effective.[34] Nevertheless, while these types of policies may satisfy an agency's mission and meet the needs of its communal living facilities, they may not always the meet the needs of an individual, substance-using client, especially one who's chronic homelessness perpetuates continued instability. As noted by the National Coalition for the Homeless, "absolute lifetime abstinence is not a reality for the majority of people with addictive disorders; relapse is an expected occurrence in the course of treatment of the disease."[35] Zero-tolerance abstinence-only based policies do not allow clients who experience drug relapses to continue participating in housing programs.

As an alternative to abstinence-only policies, agencies throughout the world have begun to employ harm reduction methods in order to manage the behavior of clients. The Harm Reduction Coalition provides a clear definition of this practice.[36]

> Harm reduction is a set of practical strategies that reduces negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

The goals of harm reduction differ from those of abstinence-based treatment. Harm reduction treatment focuses on the individual, addressing the client's drug use with motivational interviewing and psychoeducation as a means to better understand the underlying causes for the abuse. Psychoeducation refers to a type of therapy in which patients are trained to understand the nature of their disease (in this case Substance Use Disorder) in order to better deal with it.[37] Counselors help to reinforce clients' strengths, resources, and coping skills so that they may better contribute to their own wellness on a long-term basis. The idea is, that with more knowledge about their illness, clients can better live with their substance use.[38] Combined with other policies and programming techniques, harm reduction takes shape. There are guiding principles that help to define the treatment process:[39]

- The individual's decision to use drugs is accepted
- The individual is treated with dignity

---

[34] Russell (2010)
[35] National Coalition for the Homeless – Addiction Disorders and Homelessness: NCH Fact Sheet #6
[36] "Principles of Harm Reduction." *Harm Reduction Coalition*.
[37] Russell (2010)
[38] "Principles of Harm Reduction." *Harm Reduction Coalition*.
[39] National Healthcare for the Homeless Council (2010)

- The individual is expected to take responsibility for his or her own behavior
- The individual has a voice
- The goal is to reduce harm, not consumption
- Outcomes exist based upon individualized results

Harm reduction policies provide clients with individualized treatment in a safe environment and help reduce the consequential harm: overdose, HIV and Hepatitis C contraction, and infection. A variety of methods are employed to reduce such risks, including encouraging clients to switch from injecting heroin to snorting it, needle exchange programs, and opioid substitution treatment.[40] These practices allow clients the option to continue using drugs through safer means until their underlying issues can be treated.

While still fairly new to the U.S., agencies in Canada and the UK have begun to implement harm reduction policies to better reach homeless clients. Listed below are a few examples of such agencies:

Los Angeles California's Lamp Community[41] • Relapses are tolerated so long as they do not affect other clients • Units range from private to semi-private cubicles for Safe Haven and transitional housing units. • Scattered sight housing is used for its permanent supportive housing units
Chicago, Illinois' North Side Housing[42] • Utilize interim housing and permanent supportive housing • Sobriety or medication compliance is not required to access services • 72-bed capacity for interim housing and 155 grant-funded studio apartments or SRO units for supportive housing

The utilization of harm reduction programming with homeless clients will prove effective for homeless individuals who are substance users in Birmingham. Keeping clients in a facility where they feel safe and secure while providing them with the resources necessary to minimize the harms of chronic drug use could greatly improve the stability of these individuals, improving their well being before and after housing.

Best Practice for Housing Program Success

Housing First

Conceptualized in the 1990s, Housing First is a nationally recognized best practice among service providers throughout the country. This approach provides homeless individuals and

[40] Russell (2010)
[41] M.lampcommunity.org, 2014
[42] Northsidehousing.org, 2014

families with stable housing as quickly as possible before offering them services. Furthermore, while services are easily accessible, the Housing First model does not require participants to engage in these services to remain housed. Models may vary from agency to agency; however, they all share key principles as identified by the National Alliance to End Homelessness:[43]

- "A focus on helping individuals and families access and sustain permanent rental housing as quickly as possible without time limits;
- A variety of services delivered to promote housing stability and individual well-being on an as-needed basis; and
- A standard lease agreement to housing – as opposed to mandated therapy or services compliance."

Housing First programs exist in different agencies around the country, each reflecting the specific needs and preferences of their communities. A few of examples of promising models are found below:[44]

DESC 1811 Eastlake – Seattle, WA (single site)[45] • Total cost rate reduction of 53% for housed participants between 2005 and 2007 • One-year client retention rate of 66% between 2007 and 2008
Pathways to Housing, Inc. – New York, NY(multiple site)[46] • Studies found that Housing First costs city $57 per night to house client vs. $73 in shelter and $1185 in psychiatric hospital • Has housed more than 600 people in New York alone, and the program maintains an 85% retention rate
REACH – San Diego, CA (multiple site)[47] • Increased costs of case management and outpatient services are offset by reduced costs for emergency services, mental health services, and criminal justice payments

Two subpopulations of people experiencing homelessness appear to benefit the most from Housing First: those with severe mental illness and the chronically homeless. Studies have found that these groups of homeless individuals are served well by the flexible programs offered under Housing First and have higher levels of residential stability than those living in structured housing programs. Research has found that "homeless individuals who have failed almost all of the traditional treatment or housing programs have emphasized the significance of having control over their own service uptake and having program staff's respect regarding their right to move at their own pace."[48] This may indicate that Housing First programs help to provide a sense of autonomy to clients, allowing them to take charge over their path towards the promising road of

[43] National Alliance to End Homelessness. (2006).
[44] U.S. Department of Housing and Urban Development Office of Policy Development and Research (2007).
[45] Hobson (2012)
[46] Pathwaystohousing.org, 2014
[47] Gilmer, Manning and Ettner, 2009
[48] Sun, 29 (2012)

self-sufficiency. Housing First models keeps treatment options open for the client, providing education regarding the different services available without forcing clients to participate.

The Housing First approach may work well with the severely mentally ill and the chronically homeless; however, research shows that it does not serve all homeless populations as effectively. In a 2009 study, Dr. Stefan Kertesz, found that Housing First models are not optimal for housing homeless individuals who are chronic substance users, specifically those addicted to crack cocaine.[49] Generalizing Housing First as a singular best practice for all homeless groups does not serve to alleviate all homelessness. Other options should remain open with regard to treatment and housing, promoting flexible models to meet the needs of individual communities. Birmingham could benefit from employing the Housing First model for serving the mentally ill and chronically homeless.

"Wet Housing"

Agencies across the U.S. are establishing wet houses to aid homeless individuals who may be dependent upon alcohol. Seattle's DESC's 1811 Eastlake program helped to revolutionize the wet house. In 2005, DESC opened one of the first Housing First single site facilities to meet the needs of late-stage alcoholics – "active alcoholics who frequently use health care and crisis response systems."[50] This program allows participants to drink alcohol in their rooms, something contradictory to other programs designed to treat alcoholism. Four years since the DESC opened, Seattle has saved up to $1.8 million reducing of emergency room visits alone. "Furthermore, the longer individuals were enrolled in the program, the greater the reductions in cost and usage of services."[51] A recent study found that the program not only reduces costs for Seattle, but it also helps to reduce the drinking habits of clients. Alcohol use dropped from an average of 15.7 drinks daily to 10.6 after one year. These rates continued to decrease, as clients remained in the program.[52] The great success shown by DESC's program has swayed many critics. Agencies along the West Coast, nationally, and internationally have taken note of the DESC's success, modeling their own "wet houses" to treat homeless individuals suffering from alcohol abuse. The table below highlights successful programs.

DESC 1811 Eastlake – Seattle, WA[53] • Clients have been hospitalized numerous times due to alcohol use and have failed to show success in abstinence-only treatment facilities • 49 apartments available
St. Anthony Residence – St. Paul, Minnesota[54] • Late-stage chronic alcoholic men with repeated admissions to detoxification centers and a history of failure in traditional chemical dependency treatment programs • 60 units available
Stella Maris (emergency shelter) – Belfast, Ireland[55]

[49] Kertesz, 495 (2009)
[50] Hobson (2012)
[51] Ending Community Homelessness Coalition (2009)
[52] Collins, S. E., et al (2012)
[53] Foundation, 2014
[54] Cctwincities.org, 2014

- Provides a high-tolerance, low-threshold service for men and women with a history of homelessness and alcohol abuse
- 23 bed spaces per night – Single Rooms: 15 – Double Rooms: 4

After DESC's recent success with the wet house model, other cities in the U.S. have begun to push for Housing First models that cater specifically to homeless individuals suffering from alcohol abuse. In San Francisco, Bevan Dufty, director of HOPE (Housing Opportunity, Partnerships and Engagement), strives to create wet houses in the city. He believes that these programs would help stabilize homeless individuals as well as save money for the city. The San Francisco Health Department conducted a study finding that the city spends around $13.5 million per year caring for its top 225 chronic publically intoxicated homeless individuals. Wet houses could greatly reduce the cost of such services. Dufty wants to model a system after the DESC's.[56] Moving from the west coast, proponents of wet house models have spoken out in Texas, Austin specifically. City leaders are working to best utilize a wet house model to serve homeless individuals who suffer from chronic alcohol use. While a stigma may be attached to providing chronically homeless alcoholics with alcohol, the benefits wet house models are steadily coming to light. Listed below are examples of successful wet house models. Provided are different types of models and the housing structure used to provide aid to clients.

A huge advantage could be seen from wet house development in Birmingham. With the city's waning resources are already stretched thin, utilizing a shelter/housing model like one listed above could help to alleviate the costs of hospitalizing our homeless individuals suffering from chronic alcohol use. Moreover, such a program could help provide homeless individuals with a safe and stable environment, allowing them to taper their alcohol use. One Roof acknowledges that our service providers are varied in their capabilities and willingness; therefore we offer several models in which to choose.

Best Practice for Increasing Economic Security

SOAR

Homeless people experience disproportionately higher rates of disability – 36.8% of sheltered adults have a disability compared to 15.3% of adults nationally.[57] In order to aid clients in generating income, service providers use mainstream benefits. Two of these federally-administered benefits are Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). While these amenities can be greatly beneficial to homeless individuals, it is often difficult for them to qualify for such benefits in comparison to other applicants. As a result, in 2005, the Department of Health and Human Services and the Department of Housing and

---

[55] Homelessuk.org, 2014

[56] Sankin, A. (2012, February 15). Wet Houses, Homeless Shelters That Give Booze To Alcoholics, May Save San Francisco Million

[57] U.S. Department of Housing and Urban Development (2011). *The 2010 Annual Homeless Assessment Report to Congress*

Urban Development teamed up to fund the SSI/SSDI Outreach, Access, and Recovery (SOAR) initiative to improve access to these benefits for individuals who are homeless.[58] Currently, all fifty states participate in the SOAR program.

The SOAR program helps homeless individuals access resources they may otherwise be unable to apply for or get approval for. Disabling conditions may affect a person's completion of the SSI/SSDI application process. Furthermore, they may lack a relationship with a medical provider who can provide supporting documentation of their disabling conditions for an for SSI/SSDI request. Under the SOAR initiative, caseworkers are trained to assist clients with completing applications. Typically, only 10-15% of homeless applicants are approved for SSI/SSDI benefits. However, the SOAR initiative has increased overall application success by 500%. As of June 2012, 66% of applicants are approved with aid from SOAR. SSI/SSDI brought nearly $142 million into state and local economies during this 2012.[59] SOAR brings another added benefit to communities – an economic boost.

While the SOAR initiative continually works to provide homeless individuals with financial resources, it may also serve another role – preventing instability that may lead to homelessness and increasing stability that may lead to housing. As one particular case study shows, the SOAR program has the ability to enable successful reentry to men and women who have recently been released from jail or prison. For a 22-year-old man diagnosed with schizophrenia, the SOAR initiative helped to provide him income after he was released from prison. This allowed him to obtain housing and secure a stable life for himself.[60] Through the efforts of healthcare providers and an invested caseworker, this man found the stability he needed once released. Such efforts could be made with other inmates, which might help to ease reentry and lower the rate of recidivism.

CoC's and service providers throughout the country utilize effective models of SOAR. One such agency, Park Center, exists less than three hours away from Birmingham in Nashville, Tennessee. Park Center's model for SOAR relies on the following criteria for referring clients to the program:[61]

- "Individual must be chronically homeless (1 year continuous or 4 episodes of sleeping on the streets or in a shelter over the last 3 years).
- Individual must be living within Davidson County.
- Individual must have a documented mental illness diagnosis.
- Claim cannot already be in the application process with Social Security. Claim must be started from the beginning."

Adhering to the above listed criteria, SOAR Coordinators have worked to successfully aid clients in receiving SSI/SSDI benefits. In Tennessee alone, fewer than 25% of *all* applicants who apply

[58] U.S. Department of Health and Human Services (2010). *SUCCESSFULLY IMPLEMENTING SOAR: LESSONS LEARNED FROM SIX STATES*
[59] SAMHSA (2013).
[60] Dennis, D., & Abreu, D. (2010, April)
[61] Park Center

for SSI/SSDI are approved on initial application.[62] An estimated 10–15% of homeless applicants are approved. "Park Center has demonstrated a 96% success rate with homeless individuals (318 out of 330 approved as of June 2011), and while applications normally take anywhere from 120 days to two years, Park Center's average rate of determination is 64.5 days from application date."[63] These results have allowed for the continued stability of clients in the Nashville area.

Another agency that provides excellent application approval ratings for the SOAR program is the Homeless Advocacy Project in Philadelphia, Pennsylvania. This organization works to meet the legal needs of people experiencing homelessness, advocating for them in the courtroom.[64] HAP SOAR Coordinators strive to enroll as many people as possible in SSI/SSDI benefits. In fact, HAP has proven to sine as one of the most successful organizations implementing the SOAR program. "The Philadelphia program is often used by SOAR trainers around the country as the gold standard for other programs to emulate," [stated] Pamela Fischer, project officer in charge of SOAR for SAMHSA. "It's a quite effective program."[65] Coordinators have obtained a 99 percent approval of applications in an average of 32 days for 742 applicants over a four-year span.[66]

Similar organizations have utilized SOAR to promote the stabilization of clients who are not currently homeless, yet at-risk of homelessness due to re-entry into society after incarceration. Agencies work alongside local prisons to enable the successful re-entry of these clients. For instance, the Oklahoma Department of Corrections and the Oklahoma Department of Mental Health have collaborated to enable strong approval measures among SOAR applicants. "Approval rates for initial submission applications are about 90 percent. The Oklahoma SOAR program also uses peer specialists to assist with SSI/SSDI applications for persons exiting the prison system. Returns to prison within 3 years were 41 percent lower for those approved for SSI/SSDI than a comparison group."[67] These results indicate the benefits SSI/SSDI benefits play in stabilizing people who are on the verge of experiencing homelessness, keeping many of them from re-entering the criminal justice system.

One Roof already uses the SOAR program with a 97% success rate on first application. One Roof's SOAR application specialist trains other social workers and caseworkers around the state and offers technical assistance. Greater efforts could be made to facilitate SOAR's use in agencies. One Roof's model for SOAR relies on the following criteria for referring clients to the program:[68]

- Individual must be chronically homeless or homeless
- Individual must live in the area served by our Continuum of Care

[62] Park Center
[63] Park Center
[64] Homelessadvocacyproject.org, 2014
[65] Lubrano, Alfred (2012)
[66] Homeless Advocacy Project
[67] Ware, Dazara (2013)
[68] Oneroofonline (2014)

- A documented mental and/or medical illness diagnosis is preferred, but if the SOAR Specialist observes undocumented symptoms, she will help an individual start the documentation process and gather evidence
- The SOAR Specialist prefers to work with individuals who are beginning the application process, but she will assist an individual in any part of the process
- The SOAR Specialist will not assist individuals with lawyers as representatives

The SOAR program can deliver enough income to allow individuals the ability to begin finding security out of homelessness when maneuvering into a state of stability. Such income may allow clients to obtain affordable housing and supplement income earned from possible eventual employment.

Alternative Staffing Organizations

Providers and policymakers continue to develop various employment models for people experiencing homelessness. Alternative Staffing Organizations, or ASOs, "broker temporary entry-level job placements for individuals with diverse barriers to employment." Such clients may include those suffering from mental illness, physical disability, previous incarceration, or homelessness[69]ASOs function similarly to conventional staffing organizations offering companies their services to gain new hires. Unlike regular staffing organizations, ASOs hold a dual-client perspective: they provide businesses with ready-to-work employees and offer jobseekers the training they need to build a resume, learn skills, and build confidence in the job market. [70] ASOs offer participants a wide variety of support services, providing employers with funds for screening costs, hiring, payroll processing, and layoffs. All of these services are provided on a competitive fee-for-service basis.[71] ASOs offer free services to clients. Keeping the costs relegated to ASO parent organizations and business employing ASO services.

Research shows that employees served by both conventional staffing organizations and alternative staffing organizations prefer alternative staffing organizations for the support and supervision offered to employees.[72] While a variety of ASOs exist throughout the country, the most successful ASOs share similar characteristics:

- "Led by flexible, highly-motivated managers
- Supported by loyal sponsors that draw local business and funding opportunities
- Offer jobseekers a variety of support services during pre- and post-placement
- Versatile with regard to market changes and opportunities"

Built upon sound business practices with supportive methods, alternative staffing organizations provide a public service in the private sector. "This supportive and competitive approach allows a majority of ASOs to achieve significant financial self-sustainability through strong parent-

[69] Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012)
[70] Alternative Staffing Alliance. (2008)
[71] Carré, Francoise et al. (2009)
[72] Carré, Francoise et al. (2009)

organization contacts and competitive fee revenue."[73] Such measures provide communities with a cost-effective approach to hiring homeless individuals and providing employers with labor. A recent study of alternative staffing organizations found that fee revenues tend to cover at least 75 percent of operating costs while public and private grants cover the remaining expenses.[74] For the most part, ASOs costs are offset by services rendered to companies who employ their services. ASOs provide a valuable service to communities – they strengthen the economy through increased tax revenue from wages in addition to help provide economic stability to clients who were formerly unemployed.

Alternative staffing organizations are continuing to spread throughout communities across the U.S. Chrysalis Staffing at Chrysalis Enterprises in Los Angeles, California has a proven track record of success Chrysalis has worked for over two decades to assist over 45,000 people experiencing homelessness or near homelessness to find employment. In 2010, Chrysalis Enterprises contributed to $2.5 million in wages earned for over 450 participants.[75] In 2012, Chrysalis saw similar success with 1,820 jobs secured by clients involved in the program.[76] Chrysalis has helped to provide homeless individuals the tools they need to secure employment, providing them with more stepping stones that may lead to economic security.

Another organization, closer to home, works to provide employment to clients experiencing or formerly experiencing homelessness. At First-Step Staffing in Atlanta, team members work "to help homeless men and women break the cycle of homelessness, by assisting them to develop a source of sustainable income that leads to financial independence."[77] First-Step fulfills this goal by breaking down barriers which may prevent clients from obtaining employment. This is done through the following means:[78]

- "Collaboration with partner agencies – "share the work"
- Secure documentation
- Arrange transportation
- Run backgrounds and be clear about each employers' requirements
- Arrange childcare
- Encourage continuing treatment for substance abuse or mental health issues
- Computer/technical training"

Providing such services allows clients to focus on securing employment without worry of logistical issues, which may hinder the client. First-Step's track record speaks for itself: since its inception, First-Step has been able to secure employment for 300 clients per year.[79]

---

[73] Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012)
[74] Spaulding, Shane, Freely, Joshua, and Sheila Maguire. (2009)
[75] Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012)
[76] Chrysalis (2012). *Fact Sheet*.

[77] First-Step Staffing
[78] First-Step Staffing
[79] First-Step Staffing

Birmingham would greatly benefit from the alternative staffing organization model. Conventional staffing organizations already provide assistance to clients who are searching for employment. ASOs could break down the barrier for those experiencing homelessness within the city. By helping these individuals find employment, ASOs will not only benefit the individual clients but will also help to generate economic growth and provide local companies with employees.

Supported Employment

Many individuals who are homeless may suffer from mental or physical illnesses that can hinder them from obtaining employment, a key part in helping these individuals become self-sufficient. Subsequently, a model of employment has been developed to address such a need. Individualized Placement and Support is an evidence-based model for supported employment. This model is typically used for people with mental illnesses and helps them to obtain and retain employment.[80] Specifically, the IPS serves clients through the use of supported employment teams that operate within community mental health agencies. These teams work with their agency's clinical staff to coordinate services. As soon as a client at the agency expresses interest in working, he or she is referred to an employment specialist on the IPS team for an initial meeting. The employment specialist then works with the client to learn about his or her goals and preferences and provides information about how IPS works.[81] When someone chooses to enroll in IPS, that person and the employment specialist make a plan together and begin looking for regular jobs in the community as soon as the client expresses interest in doing so. These employment specialists are trained to provide people with support, coaching, resume development, interview training, and on-the-job support. Employment specialists are also trained to do job development; a process in which employment specialists build relationships with employers in businesses that have jobs that are consistent with client preferences.[82] The steps taken under the IPS to best serve clients stem from the core principles governing the model:[83]

- "Zero exclusion
- Competitive jobs are primary goal
- Integrated into mental health treatment teams
- Personalized benefits counseling
- Rapid job search
- Systematic job development
- Time-unlimited job supports
- Client centered"

These principles help to gear IPS to work with clients at their own pace, tailoring individualized supports to benefit the client as he or she finds employment.

---

[80] Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012)
[81] Herinclx, Heiei. (2009)
[82] Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012)
[83] Herinclx, Heiei. (2009)

As a means to fund this supportive model, Medicaid as well as other private and public partnerships typically fund agencies that employ the IPS model.[84] Collaborative efforts have been made to perpetuate this model, serving individuals who are attempting to gain self-sufficiency. Researchers have conducted studies to test the reliability and validity of Individualized Placement and Support. Various tests show evidence of strong placement, retention, and cost-effectiveness with the application of IPS.[85] Research shows the successes of IPS and the core principles, which secure those successes.

Research shows that employment outcomes do not vary greatly for individuals with different levels and types of mental health issues.[86] "These findings may come as a surprise to program providers and investigators who assume that supported employment is suitable for only a segment of the target population. Instead, the data indicate that IPS outcomes generalize broadly to people with SMI, with no clearly contraindicated subgroups."[87] When consumers wish to obtain employment, agencies work with each participant to assess their strengths and weaknesses, develop a plan of action, offer counseling on the potential loss of public benefits, provide skill training, and help to incorporate mental health supports with employment assistance.[88] As new issues may arise, agencies provide continual assessments of clients and offer further supports if necessary.

In addition to varying degrees of mental illness, the IPS model has shown promising results with regard to stably employing clients with co-occurring substance use disorders and mental illnesses. For example, "published studies of supported employment for individuals with mental illness and co-occurring substance abuse disorders generally find competitive employment rates between 40 and 60%. [One] study found that employment rates for those who completed drug treatment ranged between 45% and 61%."[89] While research suggests positive results for clients suffering from mental health disease and substance use disorder in a co-occurring state, the effectiveness of supported employment is more mixed with clients who suffer from substance use disorder alone.[90] Clients with a duel diagnosis are often seen to show more successful employment results.

The Individualized Placement and Support model shows promise among communities who take an innovative approach to gearing individuals toward self-sufficiency. Portland, Oregon's Central City Concern's Employment Access Center continues to utilize this model with success. Funded through the Community Development Block Grant, the City of Portland, and other private and public donations, Central City Concern provides first-class supported employment programs to homeless clients.[91] The clients that Central City Concern works with are primarily chronic substance users as well as men and women who have prior criminal histories. Specialists

---

[84] Bond, G. (2004)
[85] Bond, G.R., Becker, D.R. Drake, R.E. Rapp, C.A. Meisler, N., Lehman, A.F., Bell, M. D., &Blyer, C.R. (2001)
[86] Becker, D., Bebout, R., & Drake, R. (1998)
[87] Campbell, Bond, and Drake (2011)
[88] Cook, J., & Razzano, L. (2004)
[89] Herinckx, Heiri. (2009)
[90] Herinckx, Heiri. (2009)
[91] Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012)

help to transition these individuals permanently out of homelessness and into the labor force, finding them work in areas such as construction, business services, and retail.[92] Employment specialists tend to have an average 1:25 caseload ratio, providing as much individualized support as possible. In 2010, Central City Concern served 319 clients through supported employment. Of these clients, 71 percent found job placements and 53 percent found full-time employment. In addition, 77 percent of clients employed held employment almost a year later.[93] The majority of clients that Central City Concern serves are able to find job placements and retain placements after a year. Supported employment offers the services necessary to clients hindered by barriers such as mental illness or chronic substance abuse while providing access to the competitive job market.

In many ways Birmingham has already benefited from organizations that employ methods similar to the IPS model. For instance, the Alabama Department of Rehabilitation Services works to enable individuals suffering from mental or physical disabilities with the tools to find steady employment. Nonetheless, efforts could be continued to reach homeless individuals. The IPS model might greatly benefit Birmingham by offering homeless clients reliable support services while preparing and coaching them to find employment, breaking down the barriers preventing them from obtaining a steady job.

Conclusion

In order to make long lasting strides at eliminating homelessness in Birmingham, agencies around the city should work to implement these best practices utilized across the country. Each practice can be molded to meet the specific needs of Birmingham's homeless population. These practices build upon one another to move clients through each step of stabilization: from street outreach to potential self-sufficiency. Within the Continuum of Care, agencies around Birmingham may coordinate with one another to deliver the services and programs offered by these best practices in order to house homeless individuals and to help provide them with the tools for self-sufficiency.

Birmingham stands to gain considerably from implementing these best practices – from building a stronger community to reallocating limited funds. Providing a care system to some of the most vulnerable individuals in the city helps to strengthen our community, securing everyone a home with the support of caring neighbors and opportunities for a healthy, promising future. Many of these practices have shown great promise in helping to provide emergency assistance in addition to more permanent support.

In addition to helping build a stronger community, these best practices could greatly help eliminate the waste of unsuccessful programs as well as the costs taxpayers are often burdened with providing healthcare to homeless individuals through continuous emergency room and clinic visits. Measurable outcome evaluations might help agencies better understand which

[92] Herinckx, Heiri. (2009)
[93] Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012)

programs most effectively stabilize clients and which programs need adjusting. Instruments such as the Vulnerability Index or Vulnerability Assessment Tool could better gauge the healthcare costs and help to prioritize which individuals need the most immediate housing arrangements. Homelessness serves to negatively affect the community at large, not just the individuals experiencing it. Best practices are needed to minimize the costs inflicted upon taxpayers and upon agencies that are attempting to alleviate the issue for clients.

Agencies throughout the country that utilize the best practices illustrated in this report serve as models in the continuum of care community. They consistently find innovative methods to alleviating homelessness and strive to share their strategies with other agencies. Adopting such practices and tailoring them specifically to meet the needs of Birmingham's homeless population would allow Birmingham to take its place among these agencies, acting as a model which other cities and states may look to for guidance

Resources

Alternative Staffing Alliance. (2008). Introductory guide to Alternative Staffing. Boston, MA: Author.

Asman, A. (2013, March 27). Common Ground data reveals county's most vulnerable. *Santa Maria Sun*, *14*(3).

Bean, K. F., Shafer, M. S., & Glennon, M. (2013). The Impact of Housing First and Peer Support on People who are Medically Vulnerable and Homeless. *Psychiatric Rehabilitation Journal*, *36*(1), 48-50.

Becker, D., Bebout, R., & Drake, R. (1998). Job preferences of people with severe mental illness: A replication. *Psychiatric Rehabilitation Journal*, 22(1), 46-50. ; Campbell, K., Bond, G.R., &Drake, R.E. (2011). Who benefits from supported employment: A meta-analytic study. Schizophrenia Bulletin, 37(2), 370-380.

Bond, G. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal*, 27(4), 345-359. ; Karakus, M., Frey, W., Goldman, H., Fields, S., & Drake, R. (2011). *Federal financing of Supported Employment and Customized Employment for people with mental illnesses: Final report*. Washington, DC: U.S. Department of Health and Human Services.

Carré, Françoise et al. (2009). *Brokering up: The role of temporary staffing in overcoming labor market barriers – Report on the alternative staffing demonstration 2005–08*. Center for Social Policy.

Cctwincities.org, (2014). Housing for Chronic Alcoholics in St. Paul - Catholic Charities of St. Paul and Minneapolis. [online] Available at: http://www.cctwincities.org/StAnthony.

Central Coast Collaborative on Homelessness (2013). *2013Vulnerability Index Survey Results*.

Chrysalis (2012). *Fact Sheet*.

Collins, S. E., Malone, D. K., Clifasefi, S. L., Ginzler, J. A., Gamer, M. D., Burlingham, B., . . . Larimer, M. E. (2012). Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories. *American Journal of Public Health*, 1-9.

Community Model for Homeless People with Mental Illness (n.d.). *Training Institute*.

Community Shelter Board (2013). *The Columbus Model: Performance Measurement & Evaluation*

Community Shelter Board (2013). *Program Performance and Standards*.

Community Shelter Board, *FY2013 Program Performance Standards* (2013).

Community Solutions (n.d.). *The 100,000 Homes Vulnerability Index: Prioritizing Homeless People for Housing by Mortality Risk*.

Cook, J., & Razzano, L. (2004). Evidence-based practices in supported employment. In C.E. Stout &R.A. Hayes (Eds.), *The evidence based practice: Methods, models, and tools for mental health professionals* (pp. 10-30). New Jersey, MA: R. John Wiley & Sons Inc.

Culhane, Dennis P., Stephen Metraux, Jung M. Park, Maryanne Schretzman, and Jesse Valente. "Testing a typology of family homelessness based on patterns of public shelter utilization in four U.S. jurisdictions: Implications for policy and program planning." *Housing Policy Debate* (2007).

Dennis, D., & Abreu, D. (2010, April). SOAR: Access to Benefits Enables Successful Reentry. *Corrections Today*, 82-85.

DESC (2010). *Vulnerability Assessment Tool for Determining Eligibility and Allocating Services and Housing for Homeless Adults*.

Dunlap, N., Rynell, A., Young, M., Warland, C., & Brown, E. (2012). *Employment Program Models for People Experiencing Homelessness: Different Approaches to Program Structure*. National Transitional Jobs Network.

Ending Community Homelessness Coalition (2009). *Solutions for Homeless Chronic Alcoholics in Austin*.

Foundation, T. (2014). DESC - 1811 Eastlake. [online] Desc.org. Available at: http://www.desc.org/1811.html.

Gilmer, T., Manning, W. and Ettner, S. (2009). A cost analysis of San Diego County's REACH program for homeless persons. Psychiatric Services, 60(4), pp.445--450.

Greater Cincinnati Homeless Coalition, (2013). Need Help?. [online] Available at: http://cincihomeless.org/need-help-2/ [Accessed 12 Aug. 2014].

Herinckx, Heidi. (2009). *Central City Concern employment outcomes 2007-2009*. Portland, OR: Regional Research Institute for Human Services, Portland State University.

Homelessadvocacyproject.org, (2014). Homeless Advocacy Project (HAP) - SOAR Project. [online] Available at: http://homelessadvocacyproject.org/soar-project.html.

Homelessuk.org, (2014). Homeless UK : Depaul Ireland - Stella Maris. [online] Available at: http://www.homelessuk.org/details.asp?id=HO1008591.

Journey Home, Inc. (2010). *Results of the 2010 Capitol Region Vulnerability Index*.

Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. (2009). Housing First For Homeless Persons With Active Addiction: Are We Overreaching?. Milbank Quarterly, 87(2), 495-534.

Lamp Community - Housing + Services. (n.d.). Retrieved from http://www.lampcommunity.org/housing_services.php.

Marlowe, Jr, H. A. (2005). *Review of Best Practice in Services, Programs, and Systems Related to Homelessness* (3). Florida.

National Alliance to End Homelessness, *Becoming a Data Driven System: Columbus, Ohio.*

National Alliance to End Homelessness, *One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families* (2011).

National Alliance to End Homelessness. (2006). *What is Housing First?*

National Healthcare for the Homeless Council (2010). *HARM REDUCTION: PREPARING PEOPLE FOR CHANGE*.

Northsidehousing.org, (2014). » Programs/Services. [online] Available at: http://www.northsidehousing.org/?page_id=13.

Nunez, R., Adams, M., & Harris, S. (2011). *Does CoC Participation in SOAR Training Improve SSI/SSDI Enrollment?*. Institute for Children, Poverty, and Homelessness.

Olivet, J., McGraw, S., Grandin, M., & Bassuk, E. (2010). Staffing Challenges and Strategies for Organizations Serving Individuals who have Experienced Chronic Homelessness. *Journal of Behavioral Health Services & Research*.

Oneroofonline.org, (2014). SOAR | One Roof. [online] Available at: http://oneroofonline.org/programs/soar/.

Pathwaystohousing.org, (2014). Pathways to Housing. [online] Available at: http://pathwaystohousing.org/our-model/ [Accessed 13 Aug. 2014].

Polk County Housing Trust Fund (2012). *Combating Homelessness: Continuum of Care, Best Practices - A Study of Continuums of Care and Practical Applications to Polk County*.

"Principles of Harm Reduction." *Harm Reduction Coalition*. N.p., n.d. Web. 27 June 2013. http://harmreduction.org/about-us/principles-of-harm-reduction/.

Project H3 (2012). *What is Navigation?*. Arizona Coalition to End Homelessness.

Russell, A. (2010). Housing First and Harm Reduction: Models for Substance Abuse Treatment with Individuals who are Homeless. *Praxis, 10,* 63-69.

SAMHSA (2013). *Enhancing Benefits Acquisition Efforts Through Collaboration: SOAR SSI/SSDI Outreach, Access, and Recovery*.

Sankin, A. (2012, February 15). Wet Houses, Homeless Shelters That Give Booze To Alcoholics, May Save San Francisco Millions. *The Huffington Post* [San Francisco].

Spaulding, Shane, Freely, Joshua, & Sheila Maguire. (2009). *A foot in the door: Using alternative staffing organizations to open up opportunities for disadvantaged workers. Public/Private Ventures.*

Spence-Almaguer, E., Cronley, C., & Petrovich, J. (2013). *The Reliability and Validity of the Vulnerability Index and a Community-Based Revised Version from Fortworth, TX*.

State and County QuickFacts. (n.d.). Retrieved July 9, 2013, from http://quickfacts.census.gov/qfd/index.html.

Sun, A. P. (2012). Helping Homeless Individuals with Co-occurring Disorders: The Four Components. *Social Work*, *57*(1), 23-37.

Thecampaigntoendhomelessness.org, (2014). [online] Available at: http://www.thecampaigntoendhomelessness.org/LinkClick.aspx?fileticket=F4xWY-sq0mc%3d&tabid=68

U.S. Department of Health and Human Services (2010). *SUCCESSFULLY IMPLEMENTING SOAR: LESSONS LEARNED FROM SIX STATES*. Office of the Assistant Secretary for Planning and Evaluation.

U.S. Department of Housing and Urban Development (2010). *Centralized Intake for Helping People Experiencing Homelessness: Overview, Community Profiles, and Resources*. The Cloudburst Group.

U.S. Department of Housing and Urban Development (2011). *The 2010 Annual Homeless Assessment Report to Congress.*

Whitley, R., & Siantz, E. (2012). Recovery Centers for People With a Mental Illness: an Emerging Best Practice?. *Psychiatric Services*, *63*(1), 10-12.